

## GUEST EDITORIAL

# Triad Clinical Cancer Control Program: A Partnership for Data-Based Community Intervention

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GERALD L. WOOLAM, MD\*

*President-Elect, American Cancer Society, Atlanta, Georgia; Joe Arrington Cancer Center  
and Texas Tech University School of Medicine, Lubbock, Texas*

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Surgeons are privileged to participate directly in the care of individual cancer patients, but, in addition, many surgeons choose to expand their influence through participation in cancer control activities of organizations and institutions. Two such organizations that surgeons widely support are the American Cancer Society (ACS) and the American College of Surgeons (ACoS) Commission on Cancer (COC). The ACS and the COC have enjoyed a long-standing and mutually supportive relationship since the establishment of their predecessor entities in 1913. Despite somewhat different target audiences for their messages, the two organizations have a largely common volunteer physician base and similar goals.

The Commission on Cancer was established by the American College of Surgeons in 1965 but is now a multidisciplinary organization with membership representing 36 organizations. Its primary goal is to reduce the morbidity and mortality caused by cancer through prevention, standard-setting, monitoring and reporting on quality of care, collection of statistics regarding cancer treatment, and education. Important components in accomplishing these goals are the institutional Approvals Program, ensuring standards in the 1,500 approved programs that treat >80% of the cancers in the United States; the grassroots network of 1,800 Cancer Liaison Physicians, who volunteer their time to support local approved cancer programs; and the use of cancer registry data to improve outcomes.

The ACS is a not-for-profit organization with a highly professional staff and some 2,000,000 volunteers located in virtually every community in the country. The ACS is completing a decade-long reorganization designed to position the Society to more effectively impact cancer incidence, mortality, and quality of life for survivors through science-based and measurable cancer control initiatives, collaborations, advocacy, information services, and support of research.

The shared intent of the COC and the ACS, to reduce the morbidity and mortality caused by cancer, has led to a number of important collaborative initiatives, including clinical programs directed toward early detection of breast and colorectal cancer, implementation of American Joint Committee on Cancer (AJCC) TNM staging, promotion of clinical trial participation, and support of tobacco control in youth and young adults. The two organizations have cosponsored the AJCC and closely collaborate on the Cancer Liaison Program.

The National Cancer Data Base (NCDB) was established by the ACoS in 1988 with financial support by the ACS and compiles data on stage of diagnosis, treatment, and outcomes through voluntary submissions by hospitals and other institutions. The NCDB was designed to serve as a resource for evaluating national and regional cancer care patterns and trends and to provide data for comparative assessments of local hospital programs. Since 1995, the NCDB has been jointly governed and managed by the ACS and the ACoS, partly in an attempt to widen the audience for use of the data beyond hospital physicians to include community cancer control planners.

Although the ACoS COC, ACS, and tumor registrars have long worked together, a more formal relationship was established among these three groups in 1994 when the Triad Clinical Cancer Control Program was established, bringing together representatives from the Cancer Liaison Program, the ACS, state cancer registrar association presidents, and other interested parties, including state health department or state cancer registry representatives. The purpose of the program was to maximize the

\*Correspondence to: Gerald L. Woolam, MD, 3702 21st Street, Suite 203, Lubbock, TX 79410. E-mail: gerwoolam@aol.com

Accepted 9 June 1999

efforts of state and regional cancer-related organizations by identifying issues, developing strategies, and implementing programs to enhance cancer control at the state and local levels.

The initial project of the Triad in 1996 was directed toward evaluation of the ACS's Resources, Information, and Guidance (RIG) service programs and identification of unmet needs of newly diagnosed cancer patients. Up until that time, the ACS had no detailed information on the nationwide utilization of its patient services programs. Analysis of Triad data supported the need for reliable, unbiased, and easily accessible information on cancer, treatment options, and community resources to aid in decision-making by patients. Partly on the basis of this survey, the ACS embarked on the development of its new national cancer information system, using call centers (1-800-ACS-2345) and an enhanced web site (<http://www.cancer.org>). Plans are underway for hospitals to voluntarily report information about cancer treatment facilities to the public through the ACS information system.

More than a dozen states have now conducted Triad projects that have led to specific cooperative plans. For example, the RIG studies have formed the basis for targeted interventions for needed services in Indiana and to distribution of educational materials in Nebraska. Tobacco control and education activities for youth and adults have been planned in Colorado, Utah, and other states. Breast screening for under-served populations has been carried out by the Triad in Alabama, and breast cancer treatment evaluations, including adherence to treatment standards for early breast cancer, have been initiated in several states including Virginia, California, and North Carolina. In Ohio, the Triad has brought together additional partner organizations to develop a state cancer plan. Other Triad projects have included studies of screening and stage of diagnosis for breast, prostate, colorectal, and cervical cancers; identification of high-risk groups; and evaluation of quality of treatment data collection.

More recently, multistate Triad conferences have been held in ACS's Mid-Atlantic (DE, MD, VA, WV, and DC), and Mid-South (AL, AR, KY, LA, MS, and TN) divisions. The focus of these meetings has been on identifying information needs and ways to cooperate in regional cancer control planning. At the Mid-South Triad meeting, for example, data from the NCDB were presented, which showed significant regional differences in

treatment for prostate cancer and geographic and racial differences in stage of diagnosis for cervical and breast cancers. As the ACS develops its new nationwide cancer control program, these kinds of analyses will be useful in planning for the most effective distribution of resources and evidence-based interventions.

It is clear that there is a need for data-based targeting of cancer control activities. Despite recent success in reduction of cancer incidence and mortality, there remain significant problems in the ethnic, socioeconomic, regional, and age-specific distribution of cancer risk factors and treatment. Examples of these disparities abound. The higher risk for death from breast cancer among African-American women and the doubled risk of dying of prostate cancer among African-American men compared with white men suggest a need and opportunity to develop meaningful and tailored plans to address these differences. Similarly, youth smoking rates are increasing alarmingly nationwide, but the problem is much more acute in some regions than in others. Regional and local planning for comprehensive cancer control activities is essential if those inequities are to be specifically defined and addressed and if limited cancer control resources are to be efficiently allocated.

The potential for utilizing NCDB; state tumor registries; the Center for Disease Control and Prevention's National Center for Health Statistics; the National Cancer Institute's Surveillance, Epidemiology, and End Results program and Behavioral Risk Factor Surveillance System; the Youth Risk Behavior Survey; and other data sources for targeted cancer control intervention planning is obvious. Unfortunately, these resources have not been adequately integrated and coordinated despite ongoing efforts to move toward a single comprehensive national cancer surveillance system in the United States. The Triad program is an effort that offers some promise of moving toward the goal of data-based planning to further reduce cancer incidence and mortality and to improve the quality of life for cancer survivors.

Rapid advances in science and technology are leading to impressive opportunities to improve the early diagnosis and treatment for cancer, but ensuring access to and application of state-of-the-art care as well as encouraging the behavioral changes that can prevent cancers is a daunting task that is truly society-wide in scope. Surgeons should consider contributing to this effort by participating in organizations such as the ACS and the COC.